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**Using the Quality Maternal and Newborn Care Framework to evaluate women's  
experiences of different models of care: a qualitative study**

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## **Abstract**

**Objective.** There is evidence that continuity of care - increasingly a focus of maternity care policy in the UK - contributes to improved outcomes. However, uncertainty remains about which models of care are most effective in which circumstances, and why this is. A plausible explanation is grounded in the idea that the continuity elements of care contribute to and reinforce best quality care. The Quality Maternal and Newborn Care Framework describes the components and characteristics of quality care. As a first step in developing a maternity care evaluation toolkit, we adapted this Framework to see if it could be used to evaluate perceptions and experiences of different models of care.

**Design.** A qualitative comparative enquiry using focus groups. From a six-phase thematic analysis, we first derived then compared the principal sub-themes from the focus groups and mapped these to the original Framework.

**Setting.** Two health boards in Scotland.

**Participants.** Pregnant women, new mothers, midwives and obstetricians who had experience of various models of maternity care. This paper reports findings from the pregnant women and new mothers.

**Results.** These are presented in two parts: the seven focus groups with pregnant women and new mothers are reported in this paper; the five focus groups with midwives and obstetricians in our accompanying paper. Those using the maternity services had experience of caseloading midwifery, 'modified universal provision' and 'high risk' models of maternity care. While women from all groups shared certain perspectives, those with experience of caseloading midwifery were consistently positive, reporting positive relationships, tailored care and effective communication. Women experiencing other models of care, especially the modified universal provision model, tended to report more negative relational experiences: lack of

information, lack of tailored care, and anxiety and confusion. Timing of the focus group (i.e. during pregnancy or after the birth) appeared to make little difference to responses. Mapping responses to the Framework's characteristics of care was straightforward; mapping also showed how the Framework's components of care are interlinked.

**Key Conclusions.** Our adaptation of the Quality Maternal and Newborn Care Framework as a data collection tool allowed us to compare women with experience of different models of care, and relational factors were identifiable in many responses. Positive responses were found in all models but were most emphasised in the caseloading midwifery model, suggesting that the experience of caseloading continuity and its relational elements is highly valued. While further work is required to identify if this can be linked to improved clinical outcomes, we have established that the Quality Maternal and Newborn Care Framework can be adapted as an exploratory tool for assessing perceptions and experiences of maternity care.

**Keywords**

Models of care      Caseload midwifery      Quality of health care      Continuity of care  
Relationships      Quality Maternal and Newborn Care Framework

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## Introduction

There is growing evidence that midwife-led continuity of care models are more effective than other models (Sandall et al 2016), but there is still uncertainty about which models work best in which circumstances, and why. Globally, maternity care varies in scope and character depending on local drivers, needs and resources. A taxonomy of global antenatal care models that have been tested in a randomised controlled trial has been developed (Symon et al 2017), providing a useful basis on which to conceptualise and analyse different approaches to care provision.

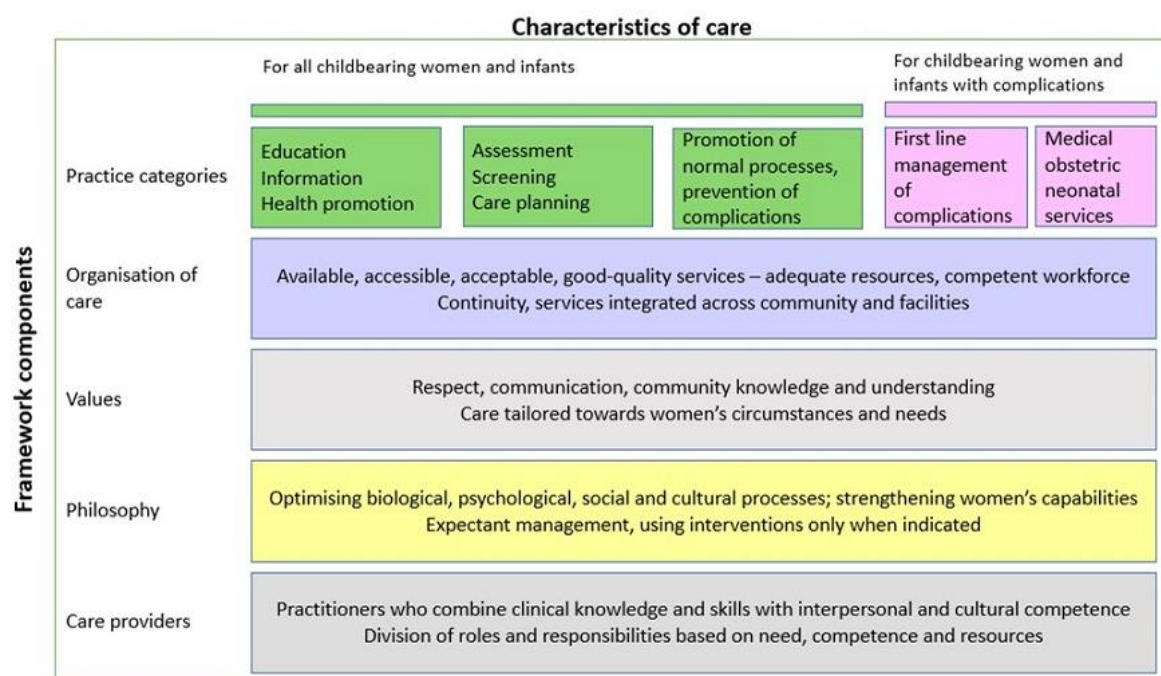
Maternity care in the United Kingdom (UK) is influenced by national policy such as *Better Births* in England (Cumberlege 2016) and *The Best Start* in Scotland (Scottish Government 2017). These arose from reviews of maternity care following significant service failure (Kirkup 2015), and growing awareness of the benefits of continuity of midwifery care (Sandall et al 2016; Homer 2016). Continuity of care has been promoted through caseload practice, an arrangement whereby an individual midwife is the primary carer for a specified number of women who are often but not always deemed ‘low risk’. This ‘primary midwife’, usually with support by a small team for when she is unavailable, provides antenatal, intrapartum and postnatal care. Tracy et al (2013) suggest that caseload midwifery in Australia is safe and cost-effective for women of any risk.

The focus in the UK is also on reducing health inequalities through improving outcomes for women from disadvantaged backgrounds (*cf.* Lindquist et al (2014)). This includes promoting continuity of care in such communities (Scottish Government 2017). The availability, efficacy and acceptability of different models of care depend on local context. Routine datasets capture essential clinical outcomes (*e.g.* rates of preterm birth, induction of labour and normal vaginal birth), and so-called ‘softer’ outcomes (the woman’s experience of care) are increasingly – though not routinely – assessed in maternity surveys (*e.g.* Cheyne et al 2015; Care Quality Commission 2017). However, the mechanisms that lead to improved outcomes associated with certain models remain poorly understood. A better understanding of these mechanisms would be significant in helping care providers to plan and deliver maternity care. Reducing preterm birth (*cf.* Sandall et al 2016), for example, would entail significant clinical, psychosocial, organisational and financial benefits.

Asserting that improved outcomes will follow on from better quality care, the Quality Maternal and Newborn Care Framework (QMNCf) presented in the Lancet Series on Midwifery

(Renfrew et al 2014) was developed following analysis and synthesis of the global literature. It describes characteristics of care that are integral to the best quality care for pregnant women, new mothers and their babies (these characteristics are seen in the coloured boxes [Figure 1]), and shows how these are clustered with five components of care ('Practice categories', 'Organisation of care', 'Values', 'Philosophy' and 'Care providers'). The QMNCF has been proposed as a structure around which improvements in midwifery can be made globally (Bharj et al 2016). It has also informed international benchmarks for antenatal care (WHO 2016), and was influential in developing *The Best Start* in Scotland, and indeed since we conducted this study it has been posited as a means by which the effectiveness of midwifery care should be evaluated (Kennedy et al 2018). However, to date it has not been used to explore the emic perspectives of those providing or experiencing these characteristics of care; nor is it known how existing antenatal, intrapartum and postnatal services match up to the QMNCF. Ultimately, it may be helpful in determining what helps or hinders the implementation or extension of successful models. Ascertaining what works and what does not will help policy-makers and service planners to identify which aspects of care provision to reinforce or replicate, and which areas need to be addressed.

**Figure 1      The Quality Maternal and Newborn Care Framework**



*Renfrew et al (2014)*

Figure 1: reprinted from *The Lancet Series on Midwifery* (doi: 10.1016/S0140-6736(14)60789-3), *Midwifery and quality care: findings from a new evidence-informed*

This is the first of two linked papers which present the findings from a study which adapted the QMNC Framework for use as a focus group topic guide to assess maternity care stakeholder perceptions and experiences. A related paper discussed the methods involved in this adaptation (Symon et al 2018). Using the QMNCF as a ‘lens’ through which different aspects of care could be evaluated, we conducted an exploratory study with various stakeholders to identify the most salient aspects of different models of care and how these are experienced. In this paper, we describe seven focus group discussions conducted with pregnant women and new mothers who between them had experience of a range of models of care. In the accompanying paper, we describe five focus group discussions with health care practitioners. This Introduction and the following Methods section apply also to the second of these two linked papers.

In the area of eastern Scotland in which we conducted the study three of the four models described in the global taxonomy (Symon et al 2017) are available: Universal provision (for all women irrespective of health state or complications); Restricted ‘lower-risk’-based provision (midwifery-led or reduced/flexible visit approach for healthy women); and Targeted ‘higher-risk’-based provision (for woman with defined clinical or socio-demographic risk factors). The Augmented provision model, which is listed in the global taxonomy, is not provided. Care is given in: tertiary units; alongside midwife-led units; a community midwife-led unit located within hospital premises; and a free-standing midwifery unit. Each of the focus groups took place in a different location: we used meeting rooms in various health centres and maternity units in the locality, and a meeting room in the local international women’s centre.

## **Materials and methods**

The research team comprised five midwives, three of whom had extensive experience in qualitative methods (one [AM] was a co-author of the QMNC Framework). The characteristics of care described in each of the QMNCF’s five components of care were distilled into a focus group topic guide (Symon et al 2018). Each of the five components of care featured a principal question with supplementary prompts. We re-framed and re-ordered some questions as part of our on-going assessment of the most effective way to stimulate productive discussions. We



then ‘mapped’ these sub-themes back to the original QMNC Framework to identify the areas of overlap and distinction in terms of the Framework’s relevant characteristics of care. This ‘mapping’ process helped to verify that the sub-themes we had identified were indeed located within the Framework, while also showing how its constituent parts were experienced.

## **Participants and recruitment**

We liaised with local midwives, health visitors and administrative staff to identify potential participants from clinic lists, and displayed advertising posters in prominent locations within the relevant clinics.

Pregnant women in the third trimester and mothers with babies up to five months of age were recruited purposively to reflect experiences of different types of care provision. Women whose babies had died or who were seriously unwell, and those under the age of 16, were not approached. Women who were deemed unable to understand the nature of the study (either through language barrier or cognitive impairment), or who were either emotionally and/or physically seriously unwell, were not eligible. Potential participants were sent an invitation letter from the local Head of Midwifery and a Participant Information Sheet, which explained the nature and purpose of the study. The women were invited to contact the study team either directly or by leaving a reply slip at the clinic or giving this to their midwife or health visitor to pass on. Those participating received a £10 ‘thank you’ shopping voucher.

We conducted seven focus groups (FGs) with service users; these lasted between 60 and 85 minutes. We also conducted five focus groups with midwives and obstetricians, which we report in the accompanying second paper. Between them, the women had experience of a range of different models of care (Table 1). Although we tried to organise the groups based on particular models of care and on timing (antenatal/postnatal), FG5 involved women from two different models, and the Caseloading group (FG7) involved both antenatal and postnatal women.

**Table 1**            **Models of care represented in the women’s focus groups**

FG3	‘High risk’ model (antenatal)	Most care provided in hospital: combination of midwifery care and specialist obstetric / other medical input
FG5	Modified* Universal provision model and ‘High risk’ model (postnatal)	‘Modified’ refers to the women having just one or two obstetric visits as well as routine care by the community midwife; in addition, some mothers were identified as ‘high risk’
FG6	‘High risk’ model (antenatal)	As FG3 above
FG7	Caseload model (antenatal and postnatal)	Mothers attended by caseloading midwives
FG8	Modified Universal provision model (postnatal)	See ‘Modified’ explanation for FG5 above
FG10	Modified Universal provision model (postnatal)	As FG5 above
FG11	Modified Universal provision model (antenatal)	As FG5 above

\*        Modified Universal provision refers to women who received most of their care from community-based midwives, but also saw a consultant obstetrician on one or two occasions

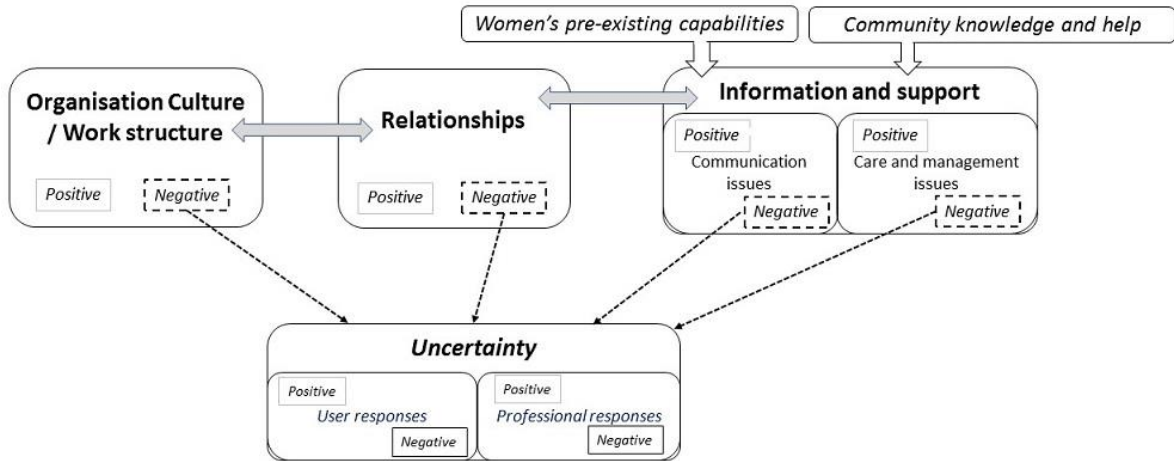
The focus groups, led by a facilitator and assisted by a note-taker, were audio-recorded and transcribed by a researcher or a professional transcriber. Data were stored securely according to university procedures. There was no pre-existing relationship between research team members and any of the women.

## **Analysis**

We used Braun and Clark’s (2006) six-phase approach of thematic analysis: familiarisation; initial coding; sorting the codes into themes and developing a provisional coding frame; reviewing the themes and the positive and negative sub-themes; shaping the final themes and sub-themes (with reference to the QMNCF); and the final write up, embedding data extracts within the analysis. As previously reported (Symon et al 2018), four main themes emerged: ‘Organisation Culture / Work Structure’; ‘Relationships’; ‘Information and support’; and

‘Uncertainty’. Each theme comprised positive and negative sub-themes; the negative sub-themes from the first three themes contributed to the fourth theme (‘Uncertainty’), which itself included positive and negative sub-themes (Figure 2).

**Figure 2** Interaction of emerging themes



In this paper, we report how we mapped the sub-themes back to the original QMNCF, identifying the relevant characteristics of care and the five components of care to which these related. For example, where we identified ‘optimising psychological processes’ and then mapped this sub-theme back to the ‘Philosophy’ component of care in the QMNCF, we report this as ‘optimising psychological processes’ (*cf.* ‘Philosophy’).

#### *Four principal sub-themes*

In order to help focus our analysis and find areas of commonality and difference we identified the four principal topics of discussion within each focus group. We explored areas of overlap and distinction firstly by the type of model of care experienced; then to see if there were any particular distinctions based on the timing of the focus group (*i.e.* whether it was before or after the birth). In the process of doing this, we were struck by the positivity or negativity of the tone of these sub-themes, leading us to an additional comparison between focus groups based on a simple positivity index.

**Ethics**

We received ethics approval for the study from the South Central – Berkshire B Research Ethics Committee (Ref.: 16/SC/0496).

## Results

Thirteen pregnant women and 18 new mothers participated in the seven focus groups. This Findings section is presented in three parts: i) the distinctions and similarities in the ‘Four principal’ sub-themes of each focus group based on model of care; ii) on whether they were antenatal or postnatal; and iii) on how positive or negative each group’s sub-themes were.

### 1 Over-lapping sub-themes between groups based on the model of care

Distinctions and similarities between the types of model of care experienced were evident. Table 2 shows the areas of overlap between the focus groups – where the four principal sub-themes were shared by at least two groups.

**Table 2 Four principal sub-themes in each focus group: areas of overlap analysed by model of care**

<b>Four principal sub-themes within each group</b>	<b>High Risk</b>	<b>MUP* + High Risk</b>	<b>MUP</b>	<b>Caseloading</b>
Lack of / barriers to information	FG3, FG6		FG8, FG11	
Anxiety / confusion	FG3, FG6		FG10	
System-driven care		FG5	FG8	
Difficulties in achieving tailored care			FG8, FG10	
Limited resources / Time	FG6		FG10	
Seeking information and support	FG3	FG5	FG10, FG11	
Positive relationships		FG5		FG7
Tailored care	FG6			FG7
Effective communication			FG11	FG7

\* MUP: Modified Universal Provision

‘Lack of / Barriers to information’, ‘Anxiety / Confusion’ and ‘Limited resources / Time’ were shared by the ‘High Risk’ and Modified Universal Provision groups. If a pregnancy was complicated there was a corresponding need for communication channels to be effective, but this did not always happen. In FG8, one woman talked of how information was lacking both before and after her pregnancy became complicated:

“I would have liked to hear the opinion of the midwife (regarding which birth unit to go to); she didn’t want to say either way, you know, which way is better or what she would recommend... I knew that (the hospital) was going to be busy and so everything was just too quick and if you didn’t ask you just didn’t get the information. They just didn’t have the time to speak to everybody...” (Alice, FG8: 197)

This highlights several negative aspects related to QMNCF characteristics of care, particularly in its ‘Values’ component of care: a lack of respect, poor communication, and care not tailored to individual needs. It can also be argued that this does not strengthen a woman’s capability or optimize her psychological processes (*cf.* ‘Philosophy’), and is an example of a practitioner not showing interpersonal competence (*cf.* ‘Care providers’).

Examples of ‘Anxiety / Confusion’ and ‘Limited resources / Time’ were, respectively:

“I’m one of these people who likes somebody to sit down and go ‘Right; this is what you should maybe expect ... you should expect this, this, this, this, this to happen and you should be asking for this, this and this... If you don’t feel well phone here if...’. That sort of thing. Even then you’re still thinking, should I PHONE maternity assessment, do I PHONE the community midwives do I PHONE your GP?” (Susie, FG3: 7) [*original emphasis*]

“I was a bit gutted that they’ve stopped doing [Parentcraft sessions] in [Town] now, partly just because of the resources, I mean the room is still there, we kind of all sent a letter in and said ‘We think it’s a disgrace that you’re not doing this anymore, because it’s good for mums, especially first-time mums’.” (Rachel, FG6: 199)

These voices can be mapped back to the characteristics of care relating to ‘Values’ in the QMNC Framework. The care the women received was not tailored to their circumstances or needs; indeed, Susie was confused by the process of communicating with different health practitioners. The care was apparently not organised in a manner that offered available and acceptable care as proposed in the Framework’s ‘Organisation of care’ component.

‘Seeking information and support’ (which arose out of the main theme ‘Uncertainty’) was shared across all groups except the Caseloading group. Examples were:

“I’m really lucky, my best friend is a midwife, so they weren’t explaining things to me so I just phoned her and asked...” (Janie, FG5: 171)

“I googled like if there was any kind of breastfeeding support groups around, because that’s my biggest worry... like who can I call ... if it’s not working out because it’s something I’m quite passionate about and I wanted it to work, but I found it hard to find the information, but then I haven’t asked my midwife, so that would probably make sense, but I don’t know if there’s groups or anything.” (Bernie; FG11: 76)

The uncertainty expressed by these women again maps back negatively to the Framework’s ‘Values’ component. Improving communication and community knowledge about resources such as breastfeeding support groups would have alleviated some of the uncertainty as expressed by these women.

Information and support comes from a variety of sources – other people, books, and magazines, and through digital technology. Referring to an international women’s online forum Shadiya said:

“There is such a wide range of women on there, they are all going through such different things, whereas the midwife might not have heard of anyone going through that before you know, because they might not have come across it. Whereas this is people from around the world having different experiences, seeing different doctors and midwives and it’s great. They are able to share that with you and it was really helpful for me. It was really supportive to me to know ‘OK, I am not alone, this is fine’.” (Shadiya, FG 10: 101)

Two MUP groups discussed ‘Difficulties in achieving tailored care’, and ‘System-driven care’ was shared by one MUP group and the combined MUP / ‘High Risk’ group. ‘Tailored care’ refers to care that is personalised to a woman’s individual needs, whereas in ‘System-driven care’ the organisation determines regimes and routines of care. Examples of this apparent lack of personalised or tailored care included:

“I was consultant-led mainly, so I didn’t really get much of a chance to build up a relationship with the community midwife or even the ones at (the community maternity unit). It was always a different midwife.” (Elaine, FG8: 36)

Facilitator: “So do you think the antenatal care is flexible, it fits in with your family needs? Or is it on a set day?” (FG8: 43)

“It’s always on a set day isn’t it? The midwives just have clinics?” (Orla, FG8: 44)

This describes an appropriate division of roles and responsibilities (*cf.* ‘Care providers’), but is negatively expressed in terms of the model’s flexibility. The system, not individual need, determines how care is provided.

The Caseloading group shared ‘Positive relationships’ with the combined MUP / ‘High Risk’ group; ‘Tailored care’ with one of the ‘High Risk’ groups; and ‘Effective communication with

one MUP group. These are all positively phrased sub-themes, which are explored below in section 3.

## 2 Over-lapping sub-themes between groups based on whether the group met before or after the birth

The same shared sub-themes were analysed by whether the group met before or after the birth, but this produced little obvious distinction, except that ‘System-driven care’ and ‘Difficulties in achieving tailored care’ (each discussed by two groups) were only discussed postnatally (Table 3).

**Table 3 Four principal sub-themes in each focus group: areas of overlap analysed by whether antenatal or postnatal**

<b>Four principal sub-themes within each group</b>	<b>Antenatal</b> (2 ‘High Risk’; 1 MUP)	<b>Antenatal / Postnatal</b> (Caseloading)	<b>Postnatal</b> (2 MUP; 1 MUP + ‘High Risk’)
Lack of / barriers to information	FG3, FG6, FG11		FG8
Anxiety / confusion	FG3, FG6		FG10
System-driven care			FG5, FG8
Difficulties in achieving tailored care			FG8, FG10
Limited resources / Time	FG6		FG10
Seeking information and support	FG3, FG11		FG5, FG10
Positive relationships		FG7	FG5
Tailored care	FG6	FG7	
Effective communication	FG11	FG7	

One parous woman gave an example of how ‘System-driven care’ ignored her own requirements:



“Yeah I think maybe if you’re a second time mum they just kind of expect you to know what you’re doing, but my first pregnancy, my daughter was born eight weeks early, so my second pregnancy was completely..... they just expected me to know, like I got less midwife appointments with my midwife because it was my second pregnancy... after I got to 20 weeks they just kind of left me to get on with it.” (Janie, FG5: 21)

Although this comment came from a postnatal group, their discussions concerned antenatal, intrapartum and postnatal issues, not just post-birth experiences. Sometimes the same issue – such as a lack of continuity – was referred to both for antenatal and postnatal care. Our analysis suggests that there is little difference between the issues raised by pregnant women and new mothers.

### **3 Four principal sub-themes from all groups, showing balance of negative and positive discussions**

The starkest comparison was noted when looking at all the four principal sub-themes from each group: the tone of the MUP groups was heavily skewed to the negative (notably FG8), while the Caseload group discussions were entirely positive. The distinction is not absolute: the caseload group shared ‘Positive relationships’ with the combined MUP / ‘High Risk’ group; ‘Tailored care’ with one of the ‘High Risk’ groups; and ‘Effective communication with one MUP group. The tone in the ‘High risk’ and mixed groups, while predominantly negative, was also positive at times (Table 4).

**Table 4**      **Four principal sub-themes in each focus group: areas of overlap analysed by model of care and whether positive or negative**

<b>Four principal sub-themes within each group</b>	<b>High Risk</b>	<b>MUP + 'High Risk'</b>	<b>MUP</b>	<b>Caseloading</b>
<i>Negative tone</i>				
Lack of / barriers to information	FG3, FG6		FG8, FG11	
Anxiety / confusion	FG3, FG6		FG10	
System-driven care		FG5	FG8	
Difficulties in achieving tailored care			FG8, FG10	
Limited resources / Time	FG6		FG10	
Criticising the system	FG3			
Poor communication			FG8	
<i>Mixed tone</i>				
Accepting uncertainty			FG11	
<i>Positive tone</i>				
Seeking information and support	FG3	FG5	FG10, FG11	
Positive relationships		FG5		FG7
Tailored care	FG6			FG7
Effective communication			FG11	FG7
Social & community support	FG5			
Accessible care				FG7

The first seven sub-themes listed in Table 4 (down to 'Poor communication'), were all negative in tone. For example, 'Lack of / barriers to information' was a sub-theme for four different groups.

"I was told I wouldn't be allowed to be induced, because you can't be induced if you've had a previous c-section." (Rachel, FG6: 115)

"See this is the thing, you get told different things. I was told that you can't get the hormone drip because that can do something with the scar, but you can get almost like..." (Morag, FG6: 116)

'Poor communication' took various forms. Sometimes there was a breakdown between the woman and the midwife:

Facilitator: "Do you feel you could have input into your own care?"

"I kind of feel that anything that I suggested or asked for information in, it was basically like, 'Well, you should already know this, you've already been here like twice kind of thing'..." (Orla, FG 8: 19)

Having described a midwife who was "lovely and I felt like I had a good relationship with her and had a chat and I could ask her anything", two women discussed the midwife's stand-in at that clinic.

"[She] was just the complete opposite ... I just thought I couldn't ask her anything and when I came in for my checks she wouldn't speak to me at all ...." (Anna, FG8: 23, 25)

"Really? She wouldn't speak to you? ...weird." (Alyshea, FG8: 26)

"Not really. You would say 'Hi', and she wouldn't say hi back, and she would check baby's heart beat and she would be like, 'Are you happy with that?' and I would be like, 'Well, you are the midwife'." (Anna, FG8: 27)

Referring back to the Framework this suggests a lack of respect and poor communication (*cf.* 'Values'), with this one practitioner not demonstrating competent interpersonal skills (*cf.* 'Care providers').

Three pregnant women at one focus group discussed how communication channels worked effectively for them between clinic appointments. For example:

"They always ring you back as well, so I think I left a message once and they rang me back the next day, just to answer a few questions that I had because I knew I wasn't seeing them for about six weeks." (Mo, FG11: 46)

"I feel like I'm annoying them all the time, I'm phoning them constantly, because this is my first time ... and they were like 'Don't worry, it's fine, you don't need to worry about it', but I feel I've been constantly on the phone panicking about something, but they're really good though, they've always phoned back..." (Anita, FG11: 47)

There was mixed reporting of communication issues: a startling example of a midwife apparently lacking in interpersonal communication skills was balanced by other participants

reporting that they found the system to be responsive, with care tailored to their needs. However, others reported a lack of tailored care:

“I don’t think they focus on you at all, it’s more about ‘Let’s check the baby’...”  
(Shadiya, FG10: 131)

This example can also be viewed as an example of a lack of respect (*cf.* ‘Values’).

Asked by the facilitator if they thought the antenatal care was flexible, fitting in with family needs, Anna responded:

“I found that really difficult as I am a high school teacher so it was only a Monday morning two-hour period so I have to go every...well not every Monday but being a high school teacher it meant I was missing the same classes each time which was quite inconvenient. It would have been better if I could miss different classes, so it was a bit frustrating...” (Anna, FG8: 48)

While the quality of the care given at these visits was not questioned, the lack of flexibility here suggests that optimum care was not available or accessible for this woman (*cf.* ‘Organisation of care’).

The sub-theme ‘accessible care’ did not feature as one of the four principal sub-themes for any of the groups except the caseload group. This included the system being flexible:

“I had to go to [the unit] a few times which was difficult because I’m working in [town]... but the midwife was always accommodating making my appointments [geographically] closer ... so that was always good, yeah, but she was pretty easy to work around.” (Laura, FG7: 104)

It also extended to referral pathways:

“I just rang and spoke to the midwife and she just said ‘Right, okay, I think you’ve got this thing, it’s quite normal, I’ll just refer you to the physio’, and [the] physio sent a letter within three days with an appointment, and that’s an amazing referral pathway...” (Trudi, FG7: 68)

## Discussion

We found that basing focus group discussions on the QMNC Framework allowed the women to comment on what was important to them about the care they had received. We analysed the discussions, producing sub-themes, which collectively developed the main themes (Symon et al 2018). It was apparent that the Framework's characteristics of care were relevant to women's experiences because we were able to map the sub-themes back to the components of care in the QMNC Framework, whether positively (indicating that the quality of care was good) or negatively (indicating that care quality had been lacking). We acknowledge that there is a certain circularity to this explanation: having started with the Framework, we asked women open questions based on it, and then were able to map their responses back to the Framework. To that criticism, we respond that any exploration of experiences about the quality of care cannot do better than base itself on the most comprehensive description to date of what quality care should comprise. It should be borne in mind that that comprehensive description emerged from a deductive and inductive analysis of the global evidence on quality care.

Our sub-themes were derived from the data, not the Framework. In mapping the sub-themes back to the Framework, we found that many were not neatly contained within the Framework classification of the components of care. Conversations frequently related to characteristics of care from more than one component of care, demonstrating how complex women's experience are, and how the Framework components are inter-related. We discuss this aspect more fully in our earlier paper (Symon et al 2018).

In terms of our ability to distinguish care experiences in different models of care, the most striking finding (shown in Tables 2 and 4) was that the caseload group (FG7), while sharing some sub-themes with other groups, was distinct in that all its four principal sub-themes were positive in tone. This aligns with other studies that have measured women's satisfaction with caseload care (or practice or model) (Forster et al 2016). The women spoke of having a positive relationship with their midwife; how communication had been effective; and how care had been tailored and accessible, even when this involved referral elsewhere. The discussions in FG8, by contrast, were negative, often covering relational issues (*e.g.* poor communication, not achieving tailored care). However, we must strike a note of caution here. Firstly, as with all qualitative research, the intention is to explore rather than to generalise, and we cannot extrapolate these findings to other models of care of the same name. Indeed, as Donnelly et al (2016) point out, while caseloading is a widely used term, it has been used to describe very different models of care. The caseload model in this study provided continuity of care during

the antenatal and postnatal period. The midwives were rostered to provide intrapartum care, so it was only by chance a woman was cared for in labour, by her caseload midwife. Nevertheless, we found this distinction in terms of the positive and negative tone of the discussions to be striking. In our accompanying paper, we report on the focus groups held with midwives and obstetricians, which offers an opportunity to triangulate some of these findings.

The other focus groups shared a mixture of positive and negative sub-themes, reflecting the positive and negative findings of other maternity care surveys (Cheyne et al 2015; Care Quality Commission 2017). It was perhaps slightly disappointing that ‘Lack of / Barriers to information’ featured so prominently, appearing in the four principal sub-themes of four groups (two with women deemed ‘High risk’, two with women accessing the modified universal provision [MUP] model). What might have been a corresponding ‘Seeking information and support’ sub-theme featured prominently in just two of these groups (one from each category). It is worth emphasising that while we have reported the areas of overlap in terms of the four principal sub-themes from each group, these sub-themes did sometimes feature in the other groups; they just were not one of the four main areas of discussion. Nevertheless, it was intriguing that the ‘High risk’ and MUP groups focussed much of their discussion on problems – a lack of information, the care being system-driven and not tailored to individual needs, and the anxiety or confusion that this sometimes created. It could be argued that these women require care tailored to their needs more so than the women without risk factors.

Identifying problems in the maternity care experience is a well-explored field. For example, the Care Quality Commission’s (2017) latest report on the NHS in England found that over two-thirds of women were not given a choice about where their antenatal care was located, and one in seven felt their midwives were not aware of their medical history. Being involved in decision-making is key: Nair et al’s (2014) meta-review highlights how information and engagement are part of a WHO (2006) framework of organisational management for improving quality of care. Basing our focus group schedule on the components and characteristics of quality care as defined in the QMNC Framework allowed us to explore what features should be present if the quality of care is good. We did not measure clinical outcomes and make no claim about the possible relationship between model of care and such outcomes. However, we have helped to show that using the QMNC Framework as a prompt is both a feasible and an enlightening way to examine the care experience, and we have identified intriguing areas of overlap and difference between women experiencing different models. This adoption of the QMNC Framework as a mechanism for evaluating care has been endorsed by senior midwifery

academics (Kennedy et al 2018). As part of the McTempo research programme (McTempo: Models of Care: The Effects on Maternal and Perinatal Outcomes) we are currently testing this approach further in studies in Australia, the Netherlands and Scotland, and another possible study is proposed for Bangladesh.

It is a feature of focus group analysis that quotes should not be taken out of context. We coded what the women said based both on the quote itself but also on its location within the context of the conversation. We have also included examples of conversations rather than just using isolated quotes to illustrate our findings. However, this process was not always straightforward because the conversations flowed, sometimes covering many aspects of the care experience. At times, a particular quote could be taken to represent other sub-themes. For example, while we coded Sophie's quote above (beginning "A couple of weeks ago...") as 'Accessible care' (which maps to the Framework component 'Organisation of care'), this could also have been coded under 'Good communication' or 'Tailored care' (*cf.* 'Values'). The quote also describes an encounter which helped to promote the woman's capabilities (*cf.* 'Philosophy') and demonstrated an appropriate division of roles and responsibilities (*cf.* 'Care providers'). 'Seeking information and support' is another interesting example: when a woman spoke about this, it could also be seen as a response to a barrier to information, or to anxiety, or to system-driven care. The fluidity of the possibilities for interpretation can be seen as a limitation. We offset this by careful discussion within the team of our coding framework, and as noted, the team contained experienced qualitative researchers.

The study has other limitations. While we recruited purposively, our intention was not to seek representativeness and we are not claiming to be able to generalise our findings. Our plan to replicate this approach in different settings may highlight diverse issues, and there are other stakeholders whose views could be included. In our accompanying paper, we report the views of midwives and obstetricians, but there is also scope to include paediatricians, maternity care assistants, administrative staff, and women's partners or other family members. The study localities do not have as great an ethnic diversity as many other areas in the UK; having one focus group (FG10) for woman who were all born outside the UK may have off-set this a little.

One non-participant (a health professional) was unexpectedly present for some of FG8. This was the most negative in tone of all the focus groups, and therefore, we feel that her presence did not introduce social desirability bias.

## **Conclusion**

This qualitative exploratory study is the first study to use the QMNC Framework as the basis for data collection, and is a first step in the development of a maternity evaluation toolkit that will help to inform maternity policy makers and service providers about quality of care. Our participants had direct experience of a variety of models of care. We found that women experiencing caseload practice were more likely to report their care experiences positively; negative experiences in other groups were often framed in relational terms. There was overlap between the focus groups on some aspects of care, including positive relationships, indicating that positive relationships occur in all models. The overlap in negative sub-themes included a lack of or barriers to information, system driven care and difficulties achieving tailored care. Identifying these issues should raise awareness among care providers; we cannot yet say whether the model of care is necessarily a factor, but our future work will help to build the evidence base on this. In our next paper, we will present the results of the analysis from the service provider focus groups that were undertaken as part of this overall study.



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